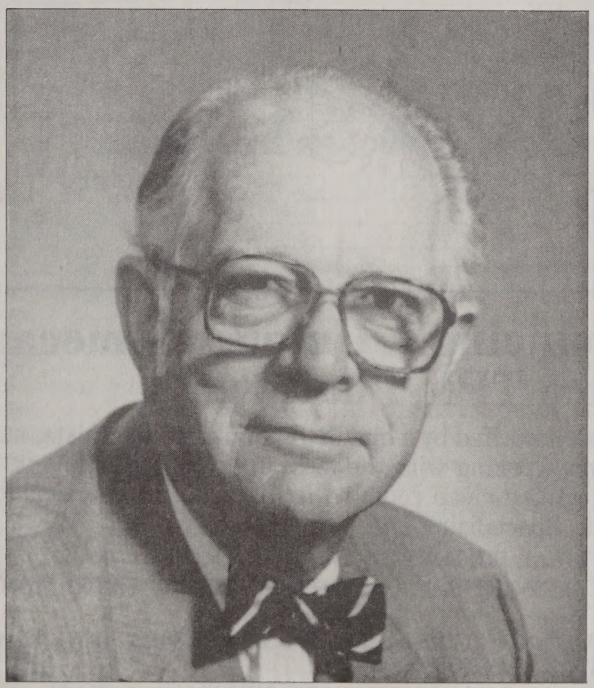
The Hampden Hippocrat

Dec. 1984
Jan. 1985



Harrison L. Rogers, M.D.

President-Elect
American Medical Association

January Meeting Speaker

Harrison L. Rogers, MD, whose picture is on this issue's cover, is the President-Elect of the AMA, and will asume office as President in June, 1985.

Born in Maryland, he went south to Emory University Medical School, then came north to intern at Yale and serve a surgical residency at Boston VA Hospital. He is a Board certified surgeon and a Fellow of the American College of Surgeons. He is currently a Clinical Assistant Professor in the Department of Surgery at Emory.

He has been active for many years in the Medical Association of Georgia and served as Speaker of the AMA House of Delegates from 1981-1984. □

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HAMPDEN DISTRICT MEDICAL SOCIETY 1984-1985 SEASON

District Meeting

PLACE:	Springfield Marriott - Baystate West
DATE:	Tuesday, January 29, 1985
HDMS BUSINESS MEETING:	6:00 p.m. (Small Conference Room)
AUXILIARY BUSINESS MEETING:	6:00 p.m. (In The Lounge Area)
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m. - Spouses are welcome! Area Legislators will be our Invited Guests
SPEAKER:	Harrison L. Rogers, M.D., President-Elect American Medical Association
SUBJECT:	THE AMA LOOKS AT THE ISSUES

If you must cancel your dinner reservation, call the office before noon on January 29th. If the cancellation is not made, you will be billed for your dinner.

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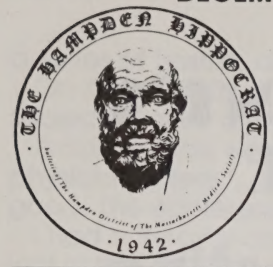
DECEMBER 1984 — JANUARY 1985 VOL. XXXXII NO. 1



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THE HAMPDEN HIPPOCRAT IS PUBLISHED BI MONTHLY.

THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

ALL COMMUNICATIONS SHOULD BE ADDRESSED TO CAROL L. NYSTROM, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109: TELEPHONE: 736-0661.

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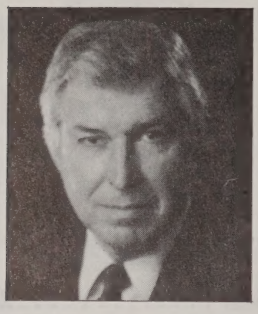

Lorne C. Smith, M.D.
President

PRESIDENT'S PAGE

An Interesting Week

After several unsuccessful attempts, I gave up trying to write a single subject President's Page. A number of unrelated events have occurred during the past week that offer food for thought.

Dr. Duncan, President of Mass. Medical Society, came to our area to hear views of several members of H.D.M.S. on two subjects. The Mass. Insurance Commissioner is holding a series of hearings this month on the subject of usual and customary method of reimbursement used by Blue Shield. Dr. Duncan was attempting to arrive at a consensus position to present at the hearing. After much discussion, I concluded that no good at all would come of these hearings. Dr. Duncan is to be commended for seeking the views of many before facing the heat of the Insurance Commissioner.

Our views of the malpractice crisis were also elicited. M.M.S. is filing one or more bills seeking relief during the current session of the legislature. I presented "Smith's" approach to the problem. That will be the subject of a future President's Page.

A few days later the new PRO rules and procedures concerning Medicare patient care arrived. These were expressed in tough, strong language.

We learned among other things that we must obtain permission from the PRO to admit and to operate upon certain Medicare patients. Early personal experience indicates that those granting approval on the PRO staff are well meaning but have never been enrolled in a Medical School.

On the same day, an explanation of the new Blue Cross - Blue Shield procedures arrived. Again the approval to admit or operate will be granted by non physicians.

A day or so later we learned that the Federal appeals court in Boston overturned the previous favorable ruling in the M.M.S. vs. Blue Shield suit concerning balance billing and related matters. The ruling among other things compared the services of a physician to the services of a house painter

A number of public relations situations developed. The subject of Infant Mortality statistics for Holyoke in 1981 was in the news almost daily. I granted a lengthy and I thought informative interview to a local reporter on this and related (Medcaid) subjects. This was followed by

a series of hostile, anti-physician, misleading articles.

On balance, a different interview with a different reporter on the subject of care of the elderly resulted in a readable, fair article.

A conference was held in Boston on the subject of "How to reduce physicians' fees". None of the suggested solutions sounded very good. The conference was widely reported in the press.

I had a lengthy conversation with a reporter from TV 40 on the subject of the PRO issues and the DRG method of hospital reimbursement. This reporter concluded that both could present serious problems for consumers. I agreed to be interviewed on each subject next week. I approach both with anxiety.

Two physicians asked for help. One was being harassed by a government agency. The other was having much difficulty as the result of new state regulations concerning laboratories in physicians' offices. The new regulations sounded unreasonable to me. We will try to help both if we can.

I can only conclude that this week we are the focus of attention from the press, the government, and some segments of the public. Professionalism is perhaps the one quality that those who chose to attack us most want to remove. The challange is clear.

Don't forget the District Meeting January 29th. Our speaker, Dr. Harrison Rogers, is in my opinion one of the most distinguished and respected physicians in organized medicine today. □

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Position Paper on Physicians' Role in Cost-Containment

The private practicing physician will become a historical curiosity in the health care system if he does not modify his behavior in response to the current demands of society. The consumers and payors of health care expect from their physicians an increase in cost-consiousness and accountability. The private practicing physician does not have the resources or the capacity to respond to these needs within the confines of his individual practice. It is therefore essential for him to combine forces with his peers in order to respond to these challanges.

The average private physician depends heavily on the presence in his community of a free work-shop (hospital) that will continue to provide the traditional kinds of services that he requires. That physician must realize that he must work with his hospital to document and maybe even modify his behavior so that his hospital can survive the challenges of prospective payment.

At the present time most of our patients still appreciate the fact that the private physician still has incentives to provide personalized and high quality medical care that frequently exceeds the incentives of the salaried physician to provide such care. Unfortunately, the marketing strategies of alternative delivery systems are rapidly convincing our patients that private care is becoming prohibitively expensive.

Rightly or wrongly, the health care analysts have identified the hospitals and the physicians as the most costly elements in the health care scene. Until recently the business community has been unwilling to get very excited about this for fear of aggravating labor. However they now have decided that health care is too espensive for them and have become very actively involved in impacting on health care management.

Despite the horrors involved in any prospective pricing system I believe that we are fortunate in Massachusetts that the business community, however capriciously, forced us into Chapter 372. I think that most of the hospitals in our state agree that we are better off with Ch. 372 than we would be with the Federal DRG system. Because 372 was developed by relatively common consensus and implemented by state legislation it is currently less regulated than the DRG system. The nature of the federal system is such that I am certain that it will generate reams of regulations and transmittals that will create the most over-regulated health care system this country has ever known. The federal government is aware that it has much less control over PPS in the waiver states and is most anxious to remove the waivers. Their success in burying Ch. 372 will depend in part on the bottom line of the cost of health care in Massachusetts in another year as com-

pared to the rest of the country. The cost effectiveness of Ch. 372 will never become a reality unless our hospitals receive more physician input and cooperation.

Now that prospective pricing is being implemented, the health care analysts are now pointing to us as the most unbridled, irresponsible element in the system. They are chomping at the bit to control our practice patterns and fees by regulation and legislation.

It is urgently imperative that private physicians generate programs of cost-containment that will at once preserve quality of care and also stay one step ahead of the regulators and legislators. If they do not act promptly we will be part of an imposed and over-regulated system. The Massachusetts Medical Society must make a concerted effort to help physicians to fulfill these needs. The Society's efforts must be entirely educational and supportive, and in no way regulatory.

The Society must develop programs that are aimed specifically at the practice patterns of physicians and the accumulation of data relative to same. This, of course, will represent a challange to our members because of their passion for individuality and confidentiality.

How can we sell such programs? What can we tell physicians is in it for them?

For starters we must educate them that their turf is very much at risk because of alternative delivery systems.

continued on next page

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Next we have to convince them that if they like the hospitals in which they practice they must help those hospitals to survive the impact of newer challanges. Lastly, we must convince them that utilization review and physician specific profiling are inevitable. They have the choice of doing it themselves or having it done to them!

How can we implement such programs? We must begin by convincing physicians that they cannot operate as individuals and expect to compete in today's market. They have to get together in some kind of peer group. We must approach this "group" concept generically. We must make it clear that we couldn't care less what kind of groups they join or create. We cannot appear to discriminate against HMO's or PPO's or IPA's or whatever. All of these groups have the capacity to effect needed changes in the system. We must, however, get across to physicians the very real risk of inappropriately formed groups creating divisiveness among the physicians. There is a difference between competition and divisiveness. I am personally intimidated by groups that start out by enlisting physicians on the basis of past profiles, which may be inaccurate and which exclude other physicians from the start. I prefer an open group that makes it clear to physicians that their survival in the group depends on their future performance.

An individual group has to have the following goals:

1) Physician education concerning utilization and quality control.
2) Careful documentation, which will make possible
3) The accumulation of meaningful data, and
4) The capacity for internal peer review.

How can the Society help? We can do the following:

1) We can develop model programs for small groups such as hospital medical staffs or communities.

2) We can develop the means for expediting data analysis by standardizing method of data retrieval and by making available to the small group state-wide data capabilities that can generate information to be returned to the original group that will enable them to compare their activities with the outside world.

Such a program will cost money. At the present time a tremendous amount of pressure is being directed at the hospitals and insurors to be more cost-effective. They will therefore welcome our efforts and should be willing to provide us with funds and support. Such efforts should have the capacity to generate grant funds if properly applied for.

We must tap the resources of our universities who have great expertise in health care. They have already manifested their willingness to help us in developing more sophisticated programs of cost-containment. We need their knowledge.

We must also interact with existing peer review organizations to develop data retrieval capabilities and to help in the educational programs of peer review concerning which they have developed considerable expertise.

Many physicians would be intimidated if they were to realize how much physician specific data has been accumulated by their own hospitals. Since we are the source of this data we should be the ones to control it. We can do so only if we access the data and put it to

work. This requires that we establish educational programs and internal peer review mechanisms that will evaluate areas in which our performance is aberrant relative to the outside world.

We also must recognize that many hospital medical staffs have already developed internal programs that are quite sophisticated in fulfilling most of the needs that I have described. The one deficiency that is common to many of them, however, is that they are operating in a vacuum and comparing themselves to themselves rather than the rest of the state.

There already exist throughout the state many physician controlled programs that fulfill many of the needs which I have addressed. However many voids exist. The Society needs to fill these voids by offering model programs that will involve all of our physicians in similar efforts.

The most basic and easily attained model can be centered in the individual hospital medical staff. Such a program need not necessarily be incorporated or even have a name. At least it would represent a start in getting physicians involved in self-assesment that will protect them from programs imposed from without.

Although many existing programs involve discounted fees or financial incentives to participation, a meaningful program need not involve these elements. It should be incentive enough for physicians to aim for maintaining an unregulated, market controlled fee structure with the knowledge that the culpability of physicians related to health care costs result not from their fees but from their generation of costs for which they receive no direct compensation.

The private, fee-for-service system in our nation has generated the hightest quality of health care that the world has ever known. All physicians who wish to preserve this system must urgently seize the initiative of involving themselves in self-assesment as it relates to cost-containment in a manner that will not compromise quality and will allow for the accumulation of data to demonstrate the effectiveness of their efforts. If we physicians don't do it somebody else will. □

J.J. Siragusa, M.D.
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Editorial

In 1980 the Graduate Medical Education National Advisory Committee (GMENAC) reported that there are, and unless something is done will continue to be, too many physicians. The announcement was received by the medical community with varying degrees of enthusiasm. The use of the delphi principle, questions of the adequacy of representation of some area of specialization and the overall rather soft data base were used by some to deny the findings. Those in the opposite camp welcomed the committee's judgement and embraced their recommendations with almost religious fervor. The Federal Government has become a tardy follower of the latter.

Some of the same concerns have been expressed over the findings of the Study on Surgical Services for the United States (SOSSUS) begun in 1970. However this investigation was more limited in scope being directly aimed at evaluation of surgical education and manpower needs. The conclusions, again in brief, were that the number of surgeons trained should be reduced. A recent study of surgeons and surgery in Rhode Island (NEJM 305;1319, 1981) suggested that neither SOSSUS nor the principals elaborated by GMENAC, which were apparent to many in the educational field long before publication, have had any significant effect.

The burgeoning numbers and especially the disparate distribution of physicians in the United States seems to be producing a shockwave effect. The GMENAC prophecy of an exploding physician population appears to be coming true sooner than anticipated. It is clearly apparent that too many medical students are being graduated. This year was more apparent than last year and that more apparent than the year before. Foreign medical graduates, U.S. citizens training in foreign medical schools, and in-situ medical students are finding it progressively more difficult to find graduate training. Even graduates of reputable American medical schools are no longer guaranteed a place in the graduate medical education system. It is no longer sufficient to have those two initials, however acquired, after their names.

The Residency training system has contracted dramatically in the last ten years both in response to the findings of GMENAC, SOSSUS and other studies and also as the result of much closer scrutiny of programs, insuring quality not quantity (incidentally another recommendation of SOSSUS). Today those fortunate enough to find a place on graduation are no longer necessarily able to find opportunities to complete their residency training and having finally finished their residency they may not be able to secure a position in practice. Board eligibility or certification no longer guarantees a place in the medical community at large.

The cost of medical care continues to spiral ever higher and the government clearly equates this with the number of physicians, although the data for such a conclusion is lacking. Cost and manpower should not be, but somehow always do seem to be intertwined. Some of the data studied by GMENAC included comparisons of rates of surgery and numbers of surgeons in Great Britain and the

United States. The putative conclusions implied that in a salaried system operations were determined by medical necessity, whereas in the fee for service model the fee determined the need. Certainly the rates of procedures such as cholecystectomy and hernia repair in the U.S. far exceed the rates in the U.K. The question whether the U.S. population seeks and receives treatment for symptoms rather than potential morbidity or mortality, whereas those in the U.K. go about their business grimly maintaining a stiff upper lip in the face of biliary colic, all the while effecting continued reaction of their hernias by discreet yet firm pressure of the hand in the trouser pocket, has not been resolved. Be that as it may, efforts to control costs by controlling physicians are likely to be intensified unless costs can be brought under control.

Sooner or later someone will have to decide if, and if so how, to restrict high cost items of health care such as the use of Intensive Care facilities by elderly patients, burn units, cardiac surgery, and many others. In some parts of the world, age alone would prohibit entry into an ICU and deny the availability of renal dialysis or the offer of a new aortic valve. Hopefully the medical profession will not only wish to but be allowed to participate in making these decisions.

Restriction of facilities may eventually result in restriction of privileges. Already high cost technology areas such as cardiac catheterization laboratories are so heavily utilized that hospitals and Chiefs of Staff have had to restrict privileges for use of these facilities in order to provide those physicians alreading credentialed ample

continued on next page

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time to maintain proficiency. In the same way increasing numbers of surgeons are clamoring to use the existing surgical facilities to operate on a patient pool which is admittedly enlarging, but more slowly than the hovering population of surgeons. Patients are getting older and living longer. They have a greater number of episodes of illness, and then need more care, but this trend is outstripped by the increase in those waiting to minister to their every need.

On a national level the problem is also apparent. The plastic surgeons and otolaryngologists have resorted to the media to determine who owns facial cosmetic surgery. Perhaps the Federal Trade Commission will make sense where apparently we have not. Some hospitals already required physicians with privileges at several hospitals to choose a primary allegiance. In other parts of the country applications for staff privileges have been lost, delayed, or plain denied. Privileges have been withdrawn with resulting lawsuits. It would appear that the more physicians there are the more litigation there will be, and the less likely will a legal equivalent of GMENAC be necessary.

Clearly HMO's, PPO's, IPA's or some form of acronmyic organized practice is the way of the future. Many physicians are already making concerted efforts to control costs by being aware of the price tags for items such as drugs, laboratory tests and radiology studies, and are limiting operating room time (currently running from $10 to $25 per minute) and hospital stays.

However, it is not just the medical community that must be educated. The public's consiousness of cost issues is sadly lacking, with the exception of the perceived overpayment of physicians. They have to realize that they cannot insist on cheaper medical care and then sue because a serum porcelain was not done. Juries must understand that malpractice costs and thence fees can only rise if they award $800,000 for an umbilicus an inch and a half off center. The cost of malpractice insurance can now exceed $60,000 per year for some surgeons. They are going to have to realize that they will not always be able to see the same physician twice, and that they may not be able to stay in hospital after operation until it is convenient for their return home and that they may have to wait longer for that operation because there are fewer surgeons or because a quota set by some faceless government arbiter has been reached. They must realize that what they do and what they want costs money, and they should insist that they be party to decisions made, not informed after the fact.

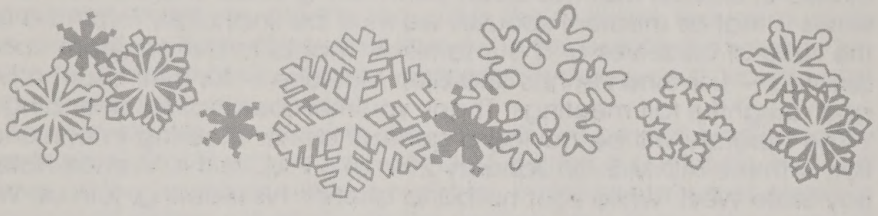
At its inception the British National Health Service was foisted on a grudgingly acquiescent medical community and a largly ignorant public, and although health care in Britian is by and large excellent, the logistics of the systems would, I believe, be unacceptable here. The government of this state and this country have already made major inroads on the way we practice and unless we, both the medical profession and the recipients of health care, insist on much greater input, and demand a say in the future, history will repeat itself and we will see the British model recreated here. □

Nicholas P.W. Coe, M.D.

Visiting Nurse Association of Springfield Celebrates 70th Anniversary

The Visiting Nurse Association of Springfield is celebrating its 70th Anniversary as a major home health care provider for the greater Springfield community. In conjunction with this celebration a 1985 Calendar has been designed and is now available for purchase. This striking Calendar contains many of the old photos dating back to 1914 when the agency was first founded and offers an interesting pictorial display of health care in the early 1900's.

For information call 781-5070. □



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Auxiliary News

This fall the H.D.M.S.A. held it's second and third series of an ongoing symposium entitled "Shared Concerns". The symposium was initiated in the fall of 1983 with the presentation of a program by a North Carolina physician's widow, Marguerite Tracy, on the financial pitfalls of widowhood. The seminar-luncheon of this series was held in October and led by author-educator Anita Taylor. In this seminar some particular medical family conflicts were reviewed and suggestions were given as to how to cope with and prevent these conflicts. Mrs. Taylor's enthusiasm and positive attitude was encouraging and supportive to all of us. The third seminar, held in November, dealt with Financial Planning — the acquiring and protection of assets, estate planning, and the disposition of money and property through trusts. Three chartered financial consultants — Jack Robinson, Robert Levitt, and Alice Lawerance — led this luncheon workshop. One major thread of advice that has been permeating these Shared Concerns series is that as medical spouses we must be financially informed for the sake of ourselves and our families. Thanks to our program coordinators — Lorraine Penhos and Ellen McGuire — for their informative and delightful fall meetings. Thank you membership, for attending.

The auxiliary will be having a general dinner meeting in conjunction with the H.D.M.S. on January 29th at 6 P.M. at the Marriott Hotel, Bay State West. While your husband attends his meeting, join us. We need your support!

—Just a Reminder—

If you haven't yet contributed to the Scholarship Fund Drive please do so. If every doctor in the H.D.M.S. were to contribute $20., the Auxiliary would raise $12,000 in scholarship funds. Give to this worthy cause! □

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What Is It?

Actually, it was conceived last spring and is now reaching the crawling stage, working towards taking its first step into the future. Eventually it will become a full fledged state wide automated medical library network with a transfacsimile system providing instantaneous photo-copy upon request from any medical library within the state.

It all began last April when the MMS Committee on Library Needs met with the representatives from the Mass. Health Sciences Library Network (MaHSLin) to form a Steering Committee to discuss the need for a more efficient information exchange system throughout the state. With the rapid advances in all aspects of health sciences, the need to know as soon as possible, if not instantaneously, is paramount. The present Inter-library Loan system which involves locating the citation, checking the Union List to see what source carries the Journal, then filling out the ILL form and offering a prayer for quick postal service as you slip the request in the mail slot, leaves much to be desired, as those of you well know who have waited a week to ten days for a photo-copy. The new proposed system would provide next day, if not same day, service.

The first step in developing the network will be accomplished by having a district library in each of the 21 districts in the MMS which will serve all the hospitals within the district. Implementation of an electronic mail system will eliminate the mailing time. The next phase will be a data base microcomputer system providing an automated inter-library loan system which will automatically route the requests to the proper source. The final stage will be the installation of telefacsimile equipment, a document transfer technology which operates like a photo-copier, tramsmitting images over communication lines thus provided instantaneous copy.

The success of this whole project depends on the dedication and cooperation between physicians, hospital administrators and medical librarians within each district. The first step is gaining the enthusiastic support of each of the 21 district Societies. Having served on the original Steering Committee and now having been appointed to serve on the Network Advisory Committee, which is made up of hospital administrators, physicians, medical librarians and New England Journal of Medicine representatives, I strongly urge all physicians and hospital administrators within HDMS to begin working together to find ways in which their institutions can play an active role in the creation of this uniqe state-wide medical library network.

By the way, it needs a catchy name. Any suggestions would be greatly appreciated and would be passed on to the Network Advisory Committee. Call 734-5445 anytime. □

Peg Stoler
Library Director

Notes and Quotes of Interest

Defensive medicine may increse the nation's medical bill by as much as $15.1 billion, according to the AMA Committee on Professiona Liability. James E. Davis, MD, speaker of the AMA House of Delegates, told a congressional hearing that the issue of professional liability costs related to such cases has become more controversial and serious than at any time since the crisis of the mid-1970's. Premiums for medical professional liability coverage have been increasing at double-digit rates in recent years, he said. Dr. Davis said the AMA does not support the medical liability legislation that has been introduced in Congress, but "we believe that the bills do provide an important focus for national discussion of the issue."

The AMA has set up a professional liability hot line to allow members to communicate directly with Association staff about malpractice and professional liability issues. The number is 800-552-4642 for those calling from outside Illinois. In Illinois, call 800-821-5309. The hot line is a project of the special task force created by Executive Vice President James H. Sammons, MD, to coordinate AMA activities in this area.

Business Is Slacking Off For Hospitals according to latest figures by the American Hospital Association. Data from 2,000 U.S. hospitals show that the average number of impatient days decreased 7.7%, admissions dropped 3.4% and the average length of stay reduced by 5%.

The High Cost of Running Hospitals in the U.S. is moderating. Hospital expenses, such as supplies, equipment and salaries, increased at a 4.8% annual rate in first six months of 1984, compared to a 12.8% jump in the first half of 1983.

Health Insurance Premiums Beginning to Drop thanks to fewer and briefer hospital stays, says U.S. News Washington Letter 10/19/84.

Women Make 43% More Visits to Doctor due to more illnesses and disabilities than men, according to figures from the National Center for Health Statistics. Exculding gynecological visits, women make 24% more visits to the doctor.

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Most are satisfied with care quality. Almost 9 in 10 Americans (88 percent) are satisfied with the quality of care they and their families recieve from doctors, reports the Health Insurance Association of America.

And almost as many (84 percent) are satisfied with the quality of care received from hospitals, the Association found in a recent nationwide survey.

But only 1 in 4 (26 percent) expressed satisfaction with the cost of medical care.

Other findings from the recent health care survey:

82 percent are satisfied with the ability to get health care when it is needed.

77 percent are satisfied with the promptness with which health insurance pays claims.

72 percent are satisfied with the medical services and the treatments covered by their health insurance.

69 percent are satisfied with the proportion of medical care costs paid by their health insurance.

Some 7 in 10 (71 percent) said they are aware that the cost of health care is going up at a faster rate than other costs. Twentyfour percent said they think health care costs are rising about as fast as other costs, while 4 percent think health costs are rising at a slower rate than other costs.

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Hospital Costs Up Eightfold in 20 Years

Patients are spending about the amount of time in community hospitals today as they did 20 years ago, but the average costs have increased more than eight times, says the Health Insurance Association of America.

The average cost to the hospital was $38.91 per patient day in 1963, the Association says. By 1982, it had risen to $327.40 per patient day, a 741 percent increase.

During that same period, the nation's cost of living as measured by the Consumer Price Index rose by 215 percent, the Association notes.

Almost half of the hospital expenses involved are for salaries and professional fees.

The table below shows the increase in community hospital costs from 1963 to 1982, the latest year for which figures are available.

Calendar year	Average cost to hospital per patient day	Average length of hospital stay (days)	Calendar year	Average cost to hospital per patient day	Average length of hospital stay (days)
1963	$38.91	7.7	1973	$102.40	7.8
1964	41.58	7.7	1974	113.60	7.8
1965	44.48	7.8	1975	133.80	7.7
1966	48.15	7.9	1976	151.80	7.7
1967	54.08	8.3	1977	174.00	7.6
1968	61.38	8.4	1978	194.30	7.6
1969	70.03	8.3	1979	217.30	7.6
1970	81.01	8.2	1980	245.10	7.6
1971	92.31	8.0	1981	284.30	7.6
1972	105.30	7.9	1982	$327.40	7.6

NOTE: Data prior to 1972 include hospital units of institutions. Total expenses include: payroll expenses; employee benefits; professional fees; depreciation expense; supplies and purchased services. Payroll expenses include: physicians' and dentists' salaries; medical and dental interns and residents; trainees in medical technology and administration; other personnel. Data for years 1973-1982 has been adjusted to include outpatients.

SOURCES: American Hospital Association, *Hospital Statistics* (various annual editions), and Health Insurance Association of America.

The American Medical Association has produced posters and brochures to help physicians explain to patients why they have chosen not to sign a "participation" agreement under the new Medicare provisions. The attractive posters and complementary brochures explain to patients that the changes in the Medicare law need not change their physician/patient relationship. The brochure explains the terms "participating" and "nonparticipating" and reassures the patient that your desire is to continue to provide quality medical care.

Our Society office has purchased a Ricoh Copy Machine and we offer a vote of thanks to Bloom's, 135 Freshwater Blvd., Enfield, Conn. for the special service they gave us.

A poster and brochures are available from Hampden District Medical Society by writing or phoning: 1414 State Street, Springfield, MA 01109 Phone: 736-0661

Number of Veterans 65 or Older to Reach 7.7 Million in 1990 and 9 million by 2000, up from 3.3 million in '81. Effect will be a great strain on Veterans Administration medical services.

Senate Armed Services Committee is considering legislation that would prevent insurance policies from excluding from coverage medical care provided free in military health care facilities even though patient has no obligation to pay. Government projects a recoup of $100 million in first year.

Japanese Have Edge In Health Cost Containment says Chrysler Vice Chairman Gerald Greenwald. U.S. health care costs averaged $6,000 per employee in '82 but only $800 per worker in Japan. Chrysler, Ford and General Motors — the "Big Three" — paid $3 billion on medical insurance alone in 1983.

Americans Won't Accept Cut Back In Health Care to poor or elderly, even in critical cost crisis, according to public opinion poll. Nor will they accept cut back on medical research, reduction in catastrophic insurance coverage or rationing of medicine.

Medicare Doubts
About 4 in 10 Americans say they are confident about the future of the Medicare system—only 8 percent being "very confident," reports the Health Insurance Association of America.

Prolonging Lives
Half the American public believes that too much is being done to prolong the lives of sick people and not enough is being done to keep them healthy in the first place, according to the Health Insurance Association of America.

1 in 25 Out Sick
In any week, about 4 percent of American workers are absent one or more days because of injury or illness—about 95 million hours, says the Health Insurance Association of America, or 2.3 percent of total hours worked by the labor force. Sick leave costs industry an estimated $7 billion a year.

Health Care Spending Increase Down To 10.3% in 1983, the smallest annual increase since 1973. Reduced rate of inflation was mostly responsible... also modest declines in the number of hospital admissions and average length of stay. Nation's total health care spending: $355 billion.

Erratum

In the previous edition of the Hippocrat, the article "Medicine - A Perspective" was erroneously attributed to the President of the Baystate Medical Center. The author, Eckart Sacchse, M.D. is president of the medical staff of the Baystate Medical Center. Our sincere apologies. □

Letter to the Editor

Dear Sir:

I object strongly to Mr. Bert Randolf Sugar's recent criticism of the American Medical Association (New York Times, Sunday, December 9 Page 2S). His view that boxing is a way out of the ghetto was shared by some at the AMA December meeting. The majority were swayed by medical evidence of permanent neurologic damage found in all professional boxers reported in such articles as Vol. 251 #20, pages 2663 and 2676 of the Journal of the AMA.

Opposing opinions deserve expression, but Mr. Sugar is in error to claim that the AMA is silent on pressing issues and makes headlines on boxing. It is the wire services that make the headlines and their coverage of the AMA conventions has been atrocious for years. The AMA considered 107 resolutions and 76 reports at its last meeting, about the same number of issues considered at each semi-annual meeting. The Medicare crisis, alternative delivery systems, federal control of medical practice through DRG's and PRO's, professional liability, long term care of the aged, and a host of scientific problems were debated at length. What does the press pick out of 4 days of serious dialogue? Boxing!!

Last year it was abuse of the elderly, the year before choke-holds, and the year before that heroin legalization. The press refuses to consider the AMA's approach to problems threatening the American public's access to quality medical care. Why doesn't the public hear about the AMA's stand on "Baby Doe's" legislation? Why hasn't the 5-year effort to create a Health Policy Agenda for the American People been heard of? Until the wire services put their headlines where the problems are, Mr. Sugar and others will continue to be at the mercy of those who strive to alienate the patient from the physician. □

Garry deN Hough, III, M.D.
Alternate Delegate
American Medical Association

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IN MEMORIAM

Roger Osterheld, M.D.

Dr. Osterheld died September 27, 1984 at age 88 in Palmer. He was superintendent of the former Monson State Hospital from 1946 to his retirement in 1969.

He was born in Stoughton, Wisconsin, served in World War I as a Navy Pahrmacist's mate and received the Purple Heart. He graduated from Colgate University and Boston University Medical School in 1924. He also was on active duty in World War II.

He was a consultant at Wing Memorial Hospital and the Veterans Administration as well, and was a recognized authority on epilepsy.

He leaves two daughters, a brother, and five grandchildren.

James W.S. Hartshorn, M.D.

Dr. Hartshorn died October 23, 1984 at home. He was 67. Born in Springfield, he graduated from Wesleyan University and Tufts Medical School. He received his surgical training at the West Roxbury V.A. Hospital after Army Medical Corps. service in World War II.

A Board certified surgeon, he was active on the Baystate Medical Center surgical staff and was a past President of the medical staff. He was also a former surgeon at the Western Mass Hospital in Westfield.

He leaves his wife, Elinor, four daughters, his mother, and two sisters.

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Executive Committee Report

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, November 19, 1984 at the Society's office. The meeting was called to order by Dr. Smith, President, at 7:30 p.m.

Present were: Drs. Smith, Hough, Hutt, Munro, O'Neill, Pacosa, Remsberg, Ryan, Stoler, Walthall and Mrs. Nystrom. Committee on Library Board of Directors: Drs. Beauchamp, Bajwa, Beachman, Carey, DeWeese, Fitzpatrick, Pelletier and Willcutts, Mrs. Stoler and Mrs. Burkin. Invited Guest: Ms. Jenny McGee, Information Support Manager, Mass. Medical Society's Publication Committee.

Ms. McGee described the proposed electronic health science library network. Mass. Medical Society's Publishing Division has established an Information Support Service Department to analyze the use of health information resources and develop services to meet these needs. The electronic library network would enhance library services and provide easy access to biomedical information. A Network Advisory Committee comprised of librarians appointed by MaHSlin has been set up. A district library will be appointed in each of the 21 state districts. The first stage will be an electronic mail system. Each district library will need at least a data terminal costing $300 and at most a microcomputer costing $4,000 to link up. Mrs. Stoler will report to HDMS on the Network Advisory Committee meetings. Dr. Smith offered the cooperation of the Society in this venture and thanked Ms. McGee and the Committee on the Library's Board of Directors

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for attending. A handout from Ms. McGee will become a part of these minutes.

The minutes of the September 17, 1984 meeting were approved.

OLD BUSINESS:

1. The motion from the Public Health Committee on Infant Mortality Statistics will be discussed at the December meeting.

2. *Rheumatoid Disease Foundation:* The AMA has stated that this Foundation is very careful to operate within the law. A letter will be sent to Dr. Antiles enclosing the material received from the AMA on this Foundation.

3. *Copy Machine:* Permission was given to purchase a Ricoh copy machine. A better price will be sought from Bloom's (a Ricoh distributor) than the price quoted by Pitney Bowes.

NEW BUSINESS:

1. *Health Planning Council Application to declare Holyoke an Underserved Area:* The Public Health Committee's motion was reviewed. After discussion, it was decided that a simple statement of approval would be sent to Western Mass. Health Planning Council.

2. *April Annual Meeting Speaker:* Dr. Smith said that Mr. John K. Springer, Administrator of Hartford Hospital has accepted our invitation to speak in April. Hospital Administrators will be our invited guests.

continued on next page

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Mr. Springer will speak on Hartford Hospital's DRG experiences.

4. *Computer Show:* Dr. Smith will contact Steven Wesler of Robert Donnell Productions. If Dr. Smith feels the program would be of value to HDMS, Mr. Wesler will be invited to the December meeting.

REPORTS:

1. The Scholarship Committee report was accepted. It was suggested that in the future, each student be listed by name, medical school and year of study. A letter will be sent to Dr. Coen, Scholarship Committee Chairman, asking him to consider giving a smaller number of students more significant sums of money next year.

2. The report on CME Program dates vs. Executive Committee Meetings was accepted. The only conflicting date was June 17th. The Executive Committee Meeting will be changed to another date in June.

3. The report on Mass. Medical Society deprived members was accepted. Two members have paid their MMS dues and have been reinstated as a result of the memo HDMS sent out.

4. Dr. O'Neill reported on the October 11th Public Hearing on Access Problems for Medicaid Recipients. Drs. O'Neill, Tauber, Siragusa and Kachinski spoke at the Hearing. Their statements were very well received by the media. Dr. O'Neill was thanked for his notable presentation on October 11th.

5. Dr. O'Neill reported that the meeting scheduled for November 16th with area legislators had to be re-scheduled to November 30th at 3 p.m. due to an emergency legislative session in Boston. On

SPECIALISTS

in malpractice insurance; excess liability; life, group, and health insurance; pension and profit sharing plans.

Henry F. Hanmer, *C.P.C.U.; C.I.C.,* **John L. Seyler**
Thomas T. Donahue, *C.P.C.U.,* **Stephen W. Fitts,** *C.P.C.U.*
Rod Goulding, *C.P.C.U.,* **Jay Josselyn,** *C.P.C.U.; A.R.M.*
Edward F. Hallet, Robert F. Wilson, Ralph A. Stirlacci

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November 30th Dr. Egan will present his perinatal mortality study and Dr. O'Neill will discuss Medicaid with the legislators.

6. Dr. Hough reviewd the changes in the governing structure of the Health Care Coalition. Andrew Brown, former executive at Monarch Life, has been chosen as a full time salaried Director. Twenty-five companies have contributed $75,000. The decision making body will be a Board of Overseers. Input to them will come from a Steering Committee. Committees working on designated projects will report to the Steering Committee.

7. On October 26th a meeting was held at Mass. Mutual to discuss the implementation of their Pre-Admission Review Program. Dr. Schwendenmann represented HDMS. Representatives from Baystate Medical Center and Mercy Hospital were also present. Mass. Mutual said they had chosen a California company, the Cost Care Company, to handle this program and asked for cooperation from the Medical Society and area hospitals. The guests present were not receptive to the use of the California company. It was stated that the Cost Care Company may negotiate with private physicians on their own.

8. Dr. Smith said the Eastern Mass. PRO, from Cambridge, Mass. will be the review organization. They will open a branch office in Palmer shortly. Dr. Hough encouraged members to hear any presentation put on by the Eastern Mass. PRO. It was felt a Press Conference in the near future should be considered.

Carol Sarno sent a thank you to the Executive Committee for her wedding gift.

There being no further business, the meeting was adjourned at 9:30 p.m.

Respectfully submitted,

William W. Walthall, Jr., M.D.
Secretary

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February 11, 1985	Skin Problems in Daily Practice Speaker: Steven Shama, MD Clinical Instructor in Medicine, Harvard Medical School Active Staff, Department of Medicine, New England Deaconess Hospital
March 11, 1985	Type II Diabetes - Diagnosis and Treatment Speaker: Richard Beaser, MD Instructor in Medicine, Harvard Medical School Department of Medicine, New England Deaconess Hospital

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Welcome New Members

Min S. Lee, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	September 30, 1953
PREMED:	Catholic Premedical College, Seoul, Korea 1972-74
MEDICAL:	Catholic Medical College, Seoul, Korea 1974-78
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center 1984-present time
SPECIALTY:	ANESTHESIOLOGY

Alfred G. Garcia, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	November 1, 1947
PREMED:	Northern Illinois University 1972-77
MEDICAL:	University of Illinois 1977-79
INTERNSHIP:	St. Joseph Hospital 1979-80
RESIDENCY:	St. Joseph Hospital 1982-84
SPECIALTY:	GENERAL SURGERY

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Adnan M. Dahdul, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	March 31, 1954
PREMED:	California State University 1975-77 Cerritos College 1973-75
MEDICAL:	Universidad Central Del Este 1977-81
INTERNSHIP:	Lemuel Shattuck, Jamacia Plain, MA 1982-83
RESIDENCY:	Baystate Medical Center 1983-present time

Sally M. McKellar, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	May 28, 1954
PREMED:	Bennet College N.C. 1972-76
MEDICAL:	Bowman Gray School of Medicine, N.C. 1976-81
INTERNSHIP:	Baystate Medical Center 1983-84
RESIDENCY:	Baystate Medical Center 1984-present time
FELLOWSHIP:	Baystate Medical Center - present time
SPECIALTY:	ANESTHESIOLOGY

Charles K. Brummer, M.D.
691 College Hgwy
Wouthwick, MA 01077

BORN:	August 26, 1949
PREMED:	Syracuse University, NY 1967-70, 77-79
MEDICAL:	Dartmouth Medical School, NH 1978-81
INTERNSHIP:	Brown Memorial Hospital 1981-82
RESIDENCY:	Brown Memorial Hospital 1982-84
SPECIALTY:	FAMILY PRACTICE

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William F. Bria, II, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	September 6, 1951
PREMED:	Georgetown University 1969-73
MEDICAL:	Georgetown University, Washington, D.C. 1973-77
INTERNSHIP:	Grady Memorial Hospital 1977-78 Emory University Hospital 1978-80
FELLOWSHIP:	Mass. General Hospital, Boston 1980-82
SPECIALTY:	INTERNAL MEDICINE/PULMONARY DISEASE

Della S. Loredo, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	November 23, 1957
PREMED:	Loma Linda University, La Sierra Campus, CA 1975-80
MEDICAL:	Loma Linda University 1980-84
INTERNSHIP:	Baystate Medical Center 1984-present time

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Douglas M. Brandt, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	February 9, 1956
PREMED:	Duke University 1974-77
MEDICAL:	Emory University School of Medicine 1978-82
INTERNSHIP:	St. Francis Hospital 1982 (July -December)
RESIDENCY:	Institute of Living Hartford, CT 1983-present time

Jack C. Lunderman, Jr., M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	February 27, 1945
PREMED:	Parsons College 1965-68
MEDICAL:	Wright State University School of Medicine 1979-84
INTERNSHIP:	Baystate Medical Center 1984-present time

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444 Montgomery St.
Chicopee, MA 01020

BORN:	October 27, 1954
PREMED:	Brown University Providence R.I. 1972-76
MEDICAL:	Brown University Medical School 1976-79
INTERNSHIP:	N.C. Memorial 1979-80
RESIDENCY:	N.C. Memorial 1980-82
FELLOWSHIP:	University of Maryland 1982-84
SPECIALTY:	PEDIATRICS

Ronald J. Davidoff, M.D.
140 High St.
Springfield, MA 01105

BORN:	January 29, 1952
PREMED:	St. John's College 1969-73
MEDICAL:	Georgetown University School of Medicine 1975-79
INTERNSHIP:	Downstate Kings County Brooklyn, NY 1979-80
RESIDENCY:	Downstate Kings County 1979-80
FELLOWSHIP:	Downstate Kings County 1982-84
SPECIALTY:	PSYCHIATRY

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Announcement

Dr. John J. Alifano, Sr. has contributed his poetry to the Hampden Hippocrat on many occasions over the years. He has now published his fifth anthology of verse entitled "My Pathways." The Springfield Sunday Republican reviewing the work commented that his "writings shine out...as works of high quality and real value, (placing) emphasis on the time - honored virtues of faith, loyalty, courage, integrity and compassion." In his introduction to the collection Joseph V. Greco, Professor Emeritus of Italian Literature at the University of Pittsburgh, credits Dr. Alfano with "a rare gift for writing music with words and ideas."

The work is available from Dr. J. Alifano, Sr., 924 Main Street, Springfield, MA 01103.

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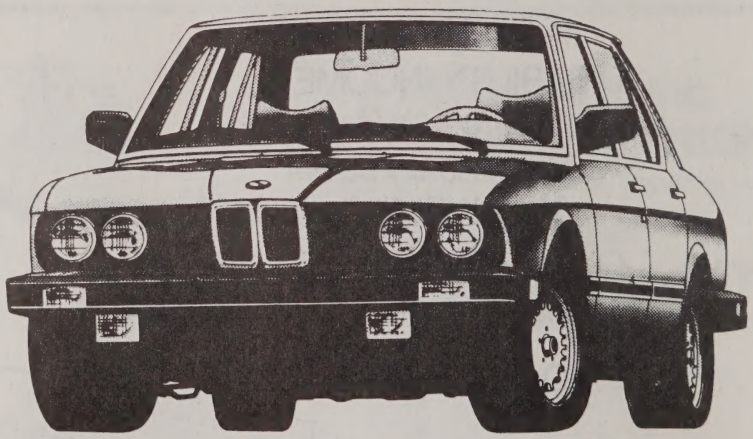

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